

Rethinking the global health system for a new international order

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In this Comment, we argue for a global health system that recognizes and supports countries as the primary agents of action, oriented around global public goods and collective action, and served by a leaner set of global and regional institutions. We present a potential vision for the functions and distribution of labor in the system to inform ongoing reform discussions and draw critique, dissent and amendment.

The global health system is in profound transition; this includes the institutions, rules, financing arrangements, norms, knowledge systems and operational mechanisms through which countries and other actors act and cooperate to protect and improve health¹. Sharp reductions in development assistance for health are disrupting services across many low-income countries (LICs) and lower middle-income countries (MICs) while forcing global organizations to retrench^{2,3}. The international order is being transformed by geopolitical fragmentation, conflict, debt, demographic change, digital technologies and the legacy of the COVID-19 pandemic⁴.

Despite its extraordinary achievements in improving health⁵, the current global health system was designed for a world that no longer exists, which has led to a consensus that global health reform is necessary, with calls for 'health sovereignty', subsidiarity, solidarity, consolidation and regionalization^{6–11}. Given the ever-decreasing proportion of a nation's resources under public control, alongside increasing transnational health threats, most countries cannot genuinely exert health sovereignty alone. As multilateralism for health comes under attack, it is ever more essential.

Change is needed; less clear is what should replace the existing model. Here we aim to answer the questions we posed a year ago on the functions of the global health system⁶. We build on our previous taxonomy of global health system functions and contexts and propose three cross-cutting, linked domains for action (Fig. 1), aspiring to support ongoing deliberations by providing reform options for critique, dissent and amendment.

Principles for a reformed global health system

Our understanding of health sovereignty is that countries and national health systems are the primary actors in the global health system, responsible for their people's health and for contributing to global

public goods for health. Countries should invest in cost-effective and equitable measures for delivering health within their maximum available resources¹², ensuring effective health policy, public health functions and service delivery, including policies to promote health across society.

The global health system should prioritize cross-border collaboration for functions that countries cannot deliver domestically by themselves or where collective action is more effective, equitable or efficient. This is the principle of subsidiarity. All countries should recognize that they benefit by engaging with the global health system. Financial support from high-income countries (HICs) cannot cease but should be reconceived as solidarity and mutual self-interest through common goods rather than as 'aid'. Global and regional health institutions need to be structured to support the central agency of countries.

The main driver for reforming the role and behavior of external actors in the global health system will be changes countries make in dealing with these actors, rather than top-down reform, and such bottom-up changes will similarly be most effective in driving restructuring of global health organizations. But external actors in the global health system also need to be willing to change, especially given the current power dynamics.

These principles require moving beyond the current fragmented architecture toward one organized around collective action and global public goods, encompassing but moving beyond traditional development assistance for health. Accountability for both health outcomes and this shift lies with countries but also with global health organizations, funders and other external actors.

Differentiated support for collective action

Organizing the system around global public goods and collective action fundamentally changes the role of external actors. Rather than delivering routine services or maintaining parallel programs, they should increasingly generate global public goods (such as research and development, regulation, and equitable access to health technologies), strengthen national institutions, and coordinate action on transnational challenges such as pandemic preparedness and surveillance. Direct substitution for nationally led service provision should become exceptional and should be relevant only in humanitarian and fragile contexts and for marginalized populations under the responsibility to protect (acknowledging trade-offs between centering equity and human rights and affirming national sovereignty).

Recognizing countries as the center of the global health system also requires acknowledging their profound variation in capacities and needs. Uniform models of engagement are neither efficient nor equitable. External support for the different domains should be differentiated according to country capacity and context (Fig. 1 and Table 1).

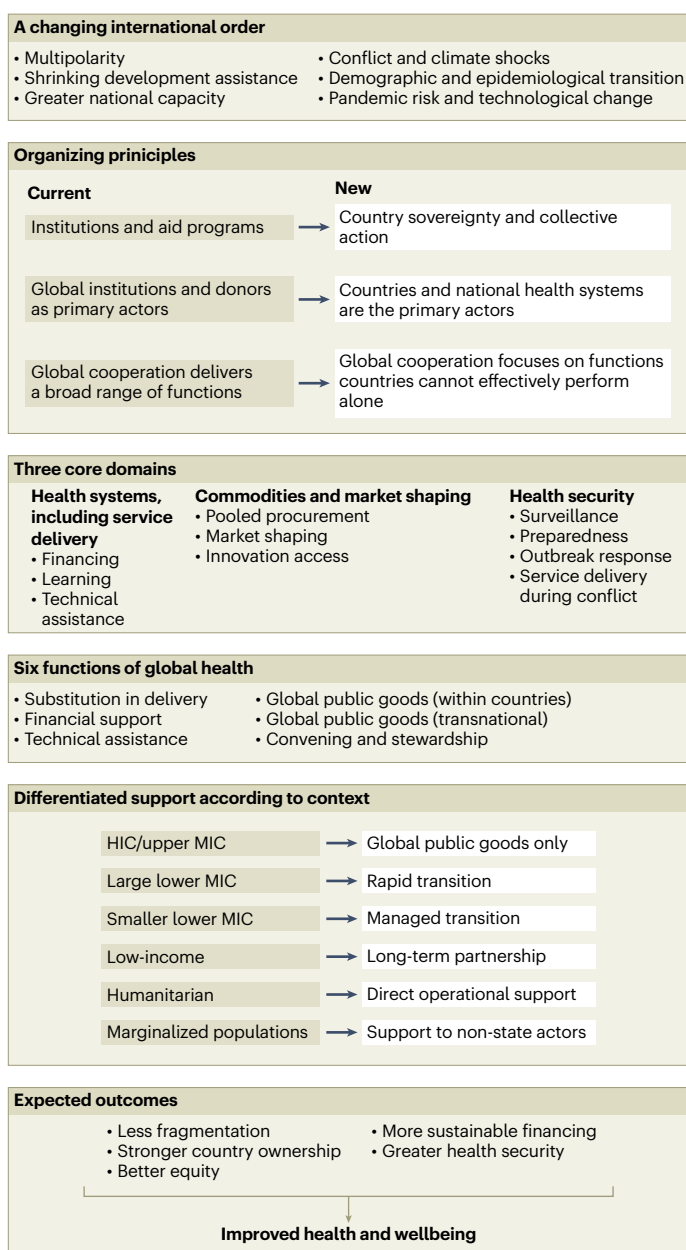


Fig. 1 | Organizing the global health system for a new international order.

HICs and upper MICs should mainly contribute to – and benefit from – global public goods. Large lower MICs should transition toward the same model by mobilizing their domestic capabilities and scale, with small lower MICs also transitioning in a longer timeframe. By contrast, LICs, humanitarian and fragile settings, and marginalized populations in exceptional circumstances will continue to require sustained international support through financing, technical assistance and, rarely, direct operational engagement.

Stable LICs will require a managed transition with continued financial and technical support, combining gradually increasing domestic financing with on-budget external support and access to innovative health technologies. Humanitarian and fragile settings should benefit

from greater support and should be the main location of substitution of delivery. These countries and settings will not be able to domestically deliver universal health coverage to their populations realistically in the next decade, given their fiscal and capacity constraints. The global community should not abandon them under the guise of health sovereignty. Where income level does not correspond to country capacity for self-reliance (for example, small island MICs), longer-term financial and technical support will also be needed.

Differentiation is therefore not a strategy for diluting solidarity but is a strategy for strengthening and focusing it. Concentrating direct support where fiscal and institutional constraints remain greatest allows global solidarity to achieve greater impact while encouraging stronger domestic leadership where countries have increasing capacity and fiscal space.

Reform of technical, financial and commodity support

The current architecture evolved through the accumulation of agencies, partnerships and financing initiatives responding to successive global priorities, which resulted in a fragmented system with duplication and inefficiency. Currently, countries must navigate multiple funding streams, reporting requirements, technical missions and implementing partners with global institutions responding mainly to separate mandates, governance arrangements and funding incentives. The solution is not simply greater coordination. Successive international agreements have promoted harmonization and country ownership without success. Tackling fragmentation will require a mixed strategy that deploys coordination, alignment, consolidation, simplification and a practice that addresses past failures of development.

A more effective model rests on three shifts: more selective external presence within countries; greater consolidation and alignment of external actors at country level at which substantive engagement continues (separating technical, financial and commodity assistance); and consolidated structures at regional and global levels to deliver functions best handled collectively. The aim is a system that reduces duplication and achieves impact while protecting those functions that require scale and global coherence.

Routine offices and large technical teams are increasingly difficult to justify in countries with substantial financial and institutional capacity. HICs and upper MICs should engage primarily with global health institutions through collaboration on global public goods, financing any continuing in-country presence they wish to retain. More intensive financing and technical engagement should instead be concentrated in LICs and humanitarian and fragile settings. This would allow global organizations to redeploy and prioritize support where it can make the greatest impact while reinforcing national ownership elsewhere.

In countries in which substantial direct external technical assistance persists, it should be integrated. Technical support from United Nations agencies and multilateral development banks should be integrated and coordinated by health ministries and the World Health Organization. But there should be increasing use of domestic institutional capabilities such as universities and think tanks. The quality and value of expensive external assistance to countries need to be higher and should aim to fill genuine technical expertise gaps; artificial intelligence could reduce reliance on external assistance while also increasing the value of validation and judgment from external actors.

Similarly, where financial support for strengthening of health systems continues, including for service delivery, it should consolidate grant and concessional loan funding by bringing together the multilateral development banks and the global health initiatives. This would,

Table 1 | Differentiated support across three domains

Country context	Health systems, including service delivery	Commodities and market shaping	Health security	Primary role of external actors
Humanitarian and fragile settings	Direct external support and service delivery where necessary	Financing and provision	Direct operational support	Substitution, technical and financing support and global public goods
Marginalized populations within countries	In exceptional circumstances, financing and technical support through non-state actors	In exceptional circumstances, financing and access to commodities through non-state actors	Global public goods	Support to local non-state actors in exceptional circumstances
LICs	Financing and technical support	Financing, access to pooled procurement and market shaping	Direct support and capacity strengthening	Long-term partnership on technical and financing support and global public goods
Smaller lower MICs	Transitional financing and technical support	Market shaping and access to pooled procurement	Capacity strengthening	Managed transition
Large lower MICs	Limited transitional financing and technical support	Access to pooled procurement and global public goods	Global public goods	Rapid transition to self-reliance
Upper MICs and HICs	Global public goods	Global public goods	Global public goods	None

however, require substantive reform of current development bank financing for health to operationalize the principles of the reformed global health system. We propose establishing a broad health systems financing mechanism learning from the successes and failures of the Global Financing Facility, aligning the health systems financing mandates of Gavi, the Vaccine Alliance (Gavi), and the Global Fund, and establishing formal links with reformed concessional loan instruments of both global and regional development banks (such as the World Bank's International Development Association).

Commodity financing (for LICs and humanitarian settings), market shaping and access to pooled or joint procurement should be consolidated, progressively rationalizing the efforts of agencies such as the Global Fund, Gavi, Unitaids and others into an innovative health technology and commodity mechanism, expanding the range of commodities covered (for example, for noncommunicable diseases and mental health) to avoid skewing health systems and to respond better to country needs. Actual procurement should be undertaken by country health systems, with substitution occurring only in exceptional circumstances, such as in humanitarian and fragile settings and for regional or global stockpiles, with regional and global support persisting for pooled procurement, drawing on successful experiences such as the Pan American Health Organization Revolving Fund.

Yet consideration of health financing by the global health system cannot be limited to specific health grants and loans. Health sovereignty cannot be achieved without economic sovereignty. Domestic resources (including those from governments, through insurance schemes and via out-of-pocket spending) already finance most health services in most countries, but expanding the fiscal space for health requires addressing debt burdens, illicit financial flows, and inequitable access to international credit markets and financing. It also requires improved domestic governance and execution of available financial resources in countries for health from public, private and individual sources.

External actors should increasingly operate through a single country-led national health platform. Rather than establishing parallel planning, financing, monitoring and reporting arrangements, bilateral agencies, multilateral organizations, development banks and global health initiatives should support country leadership and align behind one nationally defined strategy, one financing framework and

one accountability mechanism. Such an approach would modernize the principles of sector-wide approaches (which have often failed) for a far more complex and pluralistic global health landscape while substantially reducing transaction costs for governments.

Regional institutions have an increasingly important role, but regionalization is not a panacea. Many functions – including disease surveillance, regulatory harmonization, pooled procurement and manufacturing partnerships – can often be organized more effectively and with stronger ownership at a regional level than globally. Strengthening regional capacity can bring decision-making closer to countries while enabling economies of scale that individual countries cannot achieve alone. However, regionalization should not become another layer of institutional complexity. Wherever functions move to regional organizations, corresponding responsibilities should be reduced elsewhere – with a clearer division of labor between global organizations, their regional offices and regional institutions governed and financed by member states of that region.

Research and product development partnerships

Research and development are a global public good for which the global health system must continue to convene platforms to allow the exchange of knowledge, set priorities and ensure equity and benefit sharing. Most countries need to greatly increase their domestic investment across the spectrum of research, from discovery science to clinical trials to policy and implementation research, as a crucial enabler to exercising their sovereignty in health, including through generating evidence specific to their own context¹³. As a start, countries should increase investment in health research to meet their agreed 2005 target of 2% of health expenditure; most countries are currently far below this¹⁴. Investment in research also strengthens and enables a greater role for academic institutions in informing policy-making and implementation.

Research and product development for unmet health needs where there is insufficient commercial interest is a specific global public good. All countries should collaborate and co-finance this, through their own institutions, by supporting product development partnerships or by sharing risk with the private sector. The World Health Organization serves a clear role in global priority setting and target product profiles while maintaining its independence as a regulator

Table 2 | Distribution of labor of actors in the global health system

Function	Primary institution(s)
National service delivery	Countries (governments, civil society and private sector)
Research	Countries (governments, academic institutions, private sector)
Technical assistance	Domestic (institutions such as universities and thinktanks); external actors (integrated UN and MDB country platform coordinated by health ministries and WHO)
Health systems financing (grants and concessional loans)	Consolidated health systems financing mechanism integrating health systems financing functions from GFF, Gavi, the Global Fund and MDBs
Commodity financing (for LICs), market shaping and access to pooled procurement	Consolidated Global Fund or Gavi-type mechanism with only a commodity mandate
Health security financing	Non-ODA sources channeled through health system financing mechanism
Product development	Consolidated PDP ecosystem
Norms and standards	WHO
Humanitarian emergency response	Countries (government and local civil society); external actors (integrated international NGOs, UN and MDB agencies)
Outbreak preparedness and response	WHO with regional public health agencies
Regional surveillance and regulation	Regional institutions
Convening	WHO and regional agencies

GFF, Global Financing Facility; MDB, multilateral development bank; NGOs, non-governmental organizations; ODA, official development assistance; PDP, product development partnership; UN, United Nations; WHO, World Health Organization.

and broker and avoiding direct involvement in product development. The ecosystem of product-development partnerships (for vaccines, diagnostics and treatments) requires consolidation, including back-office, chemistry, manufacturing and controls, and regulatory and science functions, while remaining independent from financing and procurement organizations, even as these partnerships collaborate more closely to prepare for market shaping and demand generation as new products emerge.

Seizing the current moment for global health reform

Few of the proposals discussed above are new. The current architecture reflects the political economy of global health. Global health institutions are more than technical organizations. They embody decades of accumulated mandates, governance arrangements, funding relationships and diplomatic priorities. Donor governments value dedicated initiatives for visibility and attributable results that respond to domestic politics and constituencies and short-term political cycles. Global organizations aim to preserve mandates, budgets and country presence. Countries value external organizations as sources of expertise, employment and political engagement. Civil-society organizations fear that greater emphasis on national ownership could weaken accountability for marginalized populations with inadequate domestic protections and have their own institutional interests.

These interests are often legitimate. Together, however, they reinforce an unfit institutional architecture. Previous reform efforts have failed to tackle the underlying distribution of power. If organizations continue to respond primarily to separate governance arrangements and financing mechanisms, fragmentation will remain an inherent structural characteristic.

The current crisis changes the incentives, with substantially reduced development assistance, greater country capacities, and a more multipolar international order weakening support for a model in which a relatively small group of traditional donors shape global priorities. Maintaining a system characterized by multiple parallel financing mechanisms and extensive operational footprints is becoming increasingly difficult financially, politically and operationally.

The most important drivers of reform are therefore unlikely to be negotiations on restructuring between global organizations. Instead, they will be the cumulative decisions that countries make about how they engage with external actors. Governments can and should require external financing to align with national priorities, insist that technical assistance strengthens domestic institutions rather than substitutes for them, and consolidate fragmented partnerships into coherent country-led platforms. Individually, these changes may appear incremental; together they have the potential to reshape the incentives that govern the entire global health system.

This perspective also suggests a more pragmatic pathway for reform. The objective need not be wholesale institutional redesign before progress can occur. Shared country platforms, harmonized financing arrangements, stronger regional public goods, integrated technical assistance and pooled procurement mechanisms are all achievable within existing institutional structures. These operational changes can build trust, demonstrate value and gradually create the conditions for deeper consolidation where it improves effectiveness. However, in parallel, there should be a collective global effort to consolidate and simplify the institutional architecture. We present here a potential direction of travel (Table 2).

We acknowledge the limitations of our proposals. There is insufficient detail on potential implementation, their feasibility may rightly be challenged, and there are gaps. For example, much greater attention is required on health equity and the need to work across sectors to improve health by addressing social determinants. The fiscal space determined by uncertain economic growth and unsure commitment to increased allocation to health in MICs hamper health investment. Global health reform processes focused on efficiency and consolidation may inadvertently undermine attention to marginalized populations. Equity should be visible in representation and decision-making at global and regional levels, and in other influential mechanisms that entrench power. Health outcomes are shaped by policies across and within sectors, from climate change and agriculture to education and finance; the perennial challenge of multisectoral action may be the greatest challenge for the reformed global health system.

Conclusion

We argue for a global health system that is more differentiated, coherent, effective and sustainable. It is a system in which countries are the primary agents of action, supported by a lean and effective set of global and regional institutions organized around clearly defined functions driven by solidarity and mutual self-interest, rather than by charity. Implementing this vision will require difficult choices, including consolidation of institutions, reallocation of resources and redefinition of roles. We invite robust critique, disagreement and alternative

proposals, and we hope that our proposals can spur discussion, be used in formal processes, inform action at institutional levels, and elicit solutions to the gaps in our thinking. The current crisis cannot be squandered; the status quo is not an option⁸.

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References

1. Moon, S., Røttingen, J.-A. & Frenk, J. *Health Econ. Policy Law* **12**, 195–205 (2017).
2. Organisation for Economic Co-operation and Development. OECD <https://go.nature.com/4ggedoR> (19 June 2026).
3. World Health Organization. WHO <https://go.nature.com/4xDJWqT> (10 April 2025).
4. Carney, M. *World Economic Forum* <https://go.nature.com/4qfKWPz> (20 January 2026).
5. World Health Organization. WHO <https://go.nature.com/4cGm3a2> (13 May 2026).
6. World Health Organization. WHO <https://go.nature.com/3TLGGLH> (7 May 2026).
7. Rasanathan, K. et al. *Nat. Med.* **31**, 3605–3608 (2025).
8. Pate, M. A., Kaberuka, D. & Piot, P. *Accra Reset* <https://go.nature.com/3TWvhsr> (7 January 2026).
9. Wellcome Trust. *Wellcome* <https://go.nature.com/4i7uGxR> (March 2026).
10. Nordström, A. et al. *Lancet* **407**, 655–657 (2026).
11. Nishtar, S. *Lancet* **407**, 820–824 (2026).
12. United Nations. UN <https://go.nature.com/4x7yuUz> (1966).
13. Rasanathan, K. et al. *Lancet* **407**, 1485–1488 (2026).
14. World Health Organization. WHO <https://go.nature.com/4xDlgO7> (25 May 2005).

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Competing interests

K.R. is the executive director and G.L. and A.T. are staff of the Alliance for Health Policy and Systems Research. H.I., C.K. and S.S. are members of the Accra Reset High-Level Panel on Reform of the Global Health Architecture and Governance. J.-A.R. is the chief executive officer of the Wellcome Trust.